

<i>SERFF Tracking Number:</i>	<i>ASLX-G127845329</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>American Memorial Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>50573</i>
<i>Company Tracking Number:</i>	<i>AR01372AM00018</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
<i>Product Name:</i>	<i>Whole Life Insurance Premiums Payable for Life End</i>		
<i>Project Name/Number:</i>	<i>Whole Life Insurance Premiums Payable for Life Endowment at Age 100 Nonparticipating/AR01372AM00018</i>		

## Filing at a Glance

Company: American Memorial Life Insurance Company

Product Name: Whole Life Insurance Premiums SERFF Tr Num: ASLX- State: Arkansas

Payable for Life End G127845329

TOI: L08 Life - Other SERFF Status: Closed-Approved- State Tr Num: 50573

Closed

Sub-TOI: L08.000 Life - Other

Co Tr Num: AR01372AM00018

State Status: Approved-Closed

Filing Type: Form

Author: SPI AssurantLH

Reviewer(s): Linda Bird

Date Submitted: 12/27/2011

Disposition Date: 01/04/2012

Disposition Status: Approved-Closed

Implementation Date Requested: 01/24/2012

Implementation Date:

State Filing Description:

## General Information

Project Name: Whole Life Insurance Premiums Payable for Life  
Endowment at Age 100 Nonparticipating

Project Number: AR01372AM00018

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 01/04/2012

State Status Changed: 01/04/2012

Created By: SPI AssurantLH

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: SPI AssurantLH

Filing Description:

Please see cover letter.

## Company and Contact

### Filing Contact Information

Jennifer Drabik, Compliance Analyst

jennifer.drabik@assurant.com

440 Mount Rushmore Road

605-719-0073 [Phone] 57073 [Ext]

Rapid City, SD 57701

605-719-0473 [FAX]

SERFF Tracking Number: ASLX-G127845329 State: Arkansas  
 Filing Company: American Memorial Life Insurance Company State Tracking Number: 50573  
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 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: Whole Life Insurance Premiums Payable for Life End  
 Project Name/Number: Whole Life Insurance Premiums Payable for Life Endowment at Age 100 Nonparticipating/AR01372AM00018

### Filing Company Information

American Memorial Life Insurance Company CoCode: 67989 State of Domicile: South Dakota  
 440 Mount Rushmore Road Group Code: 19 Company Type:  
 Rapid City, SD 57701 Group Name: Assurant, Inc. Group State ID Number:  
 (605) 719-0999 ext. [Phone] FEIN Number: 46-0260270

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### Filing Fees

Fee Required? No  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Memorial Life Insurance Company	\$0.00	12/27/2011	
American Memorial Life Insurance Company	\$100.00	12/29/2011	54896065

SERFF Tracking Number: ASLX-G127845329 State: Arkansas  
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 Project Name/Number: Whole Life Insurance Premiums Payable for Life Endowment at Age 100 Nonparticipating/AR01372AM00018

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/04/2012	01/04/2012

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Linda Bird	01/03/2012	01/03/2012	SPI AssurantLH	01/03/2012	01/03/2012
Pending Industry Response	Linda Bird	12/28/2011	12/28/2011	SPI AssurantLH	12/29/2011	12/29/2011

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Application for Insurance	SPI AssurantLH	12/29/2011	12/29/2011

*SERFF Tracking Number:* ASLX-G127845329      *State:* Arkansas  
*Filing Company:* American Memorial Life Insurance Company      *State Tracking Number:* 50573  
*Company Tracking Number:* AR01372AM00018  
*TOI:* L08 Life - Other      *Sub-TOI:* L08.000 Life - Other  
*Product Name:* Whole Life Insurance Premiums Payable for Life End  
*Project Name/Number:* Whole Life Insurance Premiums Payable for Life Endowment at Age 100 Nonparticipating/AR01372AM00018

## **Disposition**

Disposition Date: 01/04/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: ASLX-G127845329 State: Arkansas

Filing Company: American Memorial Life Insurance Company State Tracking Number: 50573

Company Tracking Number: AR01372AM00018

TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: Whole Life Insurance Premiums Payable for Life End

Project Name/Number: Whole Life Insurance Premiums Payable for Life Endowment at Age 100 Nonparticipating/AR01372AM00018

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application		Yes
Supporting Document (revised)	Demo - NonSmoker, Demo - Smoker		No
Supporting Document	Demo - NonSmoker, Demo - Smoker		No
Supporting Document	Guaranty Assoc. Notice		Yes
Supporting Document	Compliance Certification		Yes
Supporting Document	ADM-7100		Yes
Supporting Document	Flesch Certification		Yes
Supporting Document	Cover Letter		Yes
Form	Whole Life Insurance Premiums Payable for Life		Yes
Form (revised)	Application for Insurance		Yes
Form	Application for Insurance		Yes

SERFF Tracking Number: ASLX-G127845329 State: Arkansas  
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Product Name: Whole Life Insurance Premiums Payable for Life End  
Project Name/Number: Whole Life Insurance Premiums Payable for Life Endowment at Age 100 Nonparticipating/AR01372AM00018

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 01/03/2012  
Submitted Date 01/03/2012  
Respond By Date 02/03/2012

Dear Jennifer Drabik,

This will acknowledge receipt of the captioned filing.

### Objection 1

Comment: The Actuarial Memorandum submitted with this filing was for Form P-1075-S - Modified Benefit Whole Life.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

SERFF Tracking Number: ASLX-G127845329 State: Arkansas  
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TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Whole Life Insurance Premiums Payable for Life End  
Project Name/Number: Whole Life Insurance Premiums Payable for Life Endowment at Age 100 Nonparticipating/AR01372AM00018

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 01/03/2012  
Submitted Date 01/03/2012

Dear Linda Bird,

### Comments:

I apologize, the correct actuarial memorandum are attached.

### Response 1

Comments: The correct Actuarial Memorandum are attached.

### Related Objection 1

Comment:

The Actuarial Memorandum submitted with this filing was for Form P-1075-S - Modified Benefit Whole Life.

### Changed Items:

#### Supporting Document Schedule Item Changes

Satisfied -Name: Demo - NonSmoker, Demo - Smoker

Comment: Actuarial Memorandum

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Please let me know if you have any additional questions. Thank you.

Sincerely,  
SPI AssurantLH

SERFF Tracking Number: ASLX-G127845329 State: Arkansas  
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Company Tracking Number: AR01372AM00018  
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Project Name/Number: Whole Life Insurance Premiums Payable for Life Endowment at Age 100 Nonparticipating/AR01372AM00018

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 12/28/2011  
Submitted Date 12/28/2011  
Respond By Date 01/30/2012

Dear Jennifer Drabik,

This will acknowledge receipt of the captioned filing.

### Objection 1

Comment: Regulation 57 was revised effective January 2010. the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the \$100.00 filing fee is received.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird



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Filing Company: American Memorial Life Insurance Company State Tracking Number: 50573  
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Product Name: Whole Life Insurance Premiums Payable for Life End  
Project Name/Number: Whole Life Insurance Premiums Payable for Life Endowment at Age 100 Nonparticipating/AR01372AM00018

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 12/29/2011  
Submitted Date 12/29/2011

Dear Linda Bird,

### Comments:

The fee has been submitted.

### Response 1

Comments: The fee has been submitted.

### Related Objection 1

Comment:

Regulation 57 was revised effective January 2010. the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the \$100.00 filing fee is received.

### Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Please let me know if you have any additional questions. Thank you.

Sincerely,  
SPI AssurantLH

SERFF Tracking Number: ASLX-G127845329 State: Arkansas

Filing Company: American Memorial Life Insurance Company State Tracking Number: 50573

Company Tracking Number: AR01372AM00018

TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: Whole Life Insurance Premiums Payable for Life End

Project Name/Number: Whole Life Insurance Premiums Payable for Life Endowment at Age 100 Nonparticipating/AR01372AM00018

**Amendment Letter**

Submitted Date: 12/29/2011

**Comments:**

I apologize I attached the incorrect application. Please replace with the newly attached version. If you have any questions, please let me know. Thank you.

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
P-1146-AR	Application/EApplication nrollment Form	Application for Insurance	Initial				50.000	P-1146-AR 6-11.PDF

SERFF Tracking Number: ASLX-G127845329 State: Arkansas

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Product Name: Whole Life Insurance Premiums Payable for Life End

Project Name/Number: Whole Life Insurance Premiums Payable for Life Endowment at Age 100 Nonparticipating/AR01372AM00018

## Form Schedule

### Lead Form Number:

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	P-1074-S	Policy/Cont Whole Life Insurance Initial ract/Fratern Premiums Payable al for Life Certificate	Initial		50.000	ar 1074.PDF
	P-1146-AR	Application/ Application for Enrollment Insurance Form	Initial		50.000	P-1146-AR 6- 11.PDF



A Stock Company

440 Mt. Rushmore Road  
P.O. Box 2730  
Rapid City, SD 57709-2730

**READ YOUR POLICY CAREFULLY**

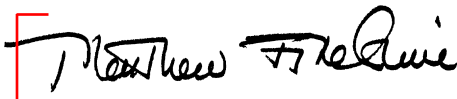
**THIS POLICY IS A LEGAL CONTRACT BETWEEN YOU AND US.**


If the insured dies while this policy is in force, we will pay the death benefit to the beneficiary, subject to the provisions of this policy.

This policy is issued in consideration of the application and payment of the first premium before delivery of this policy.

**Right to Cancel.** You may cancel this policy by returning it to our home office by midnight of the thirtieth (30<sup>th</sup>) day after the date you receive the policy. Cancellation is effective when notice is given and the policy is returned by mail that is postmarked, properly addressed, and postage prepaid. We will then refund all premiums paid.

Signed for American Memorial Life Insurance Company on the issue date at its home office in Rapid City, South Dakota.

  
Assistant Secretary

  
President

**WHOLE LIFE INSURANCE  
PREMIUMS PAYABLE FOR LIFE  
ENDOWMENT AT AGE 100  
NONPARTICIPATING**

## POLICY DATA PAGE

POLICY NUMBER 8-001001 \$1,000 INITIAL FACE AMOUNT  
INSURED NAME JOHN DOE  
ISSUE DATE 01-31-2011  
AGE AT ISSUE 35 MALE SEX NICOTINE  
POLICY OWNER JOHN DOE  
PLAN WHOLE LIFE INSURANCE - PREMIUMS PAYABLE FOR LIFE  
BENEFICIARY SEE ATTACHED APPLICATION

	ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY
DIRECT BILLING	57.41**	29.28	14.93	N/A
PRE-AUTHORIZED CHECK	57.41	29.28	14.93	5.17

THE "\*\*\*" FLAGS THE INITIAL MODE OF PAYMENT.

### SCHEDULE OF PREMIUMS

BIRTHDAY	ANNUAL PREMIUM
1-01-1976	57.41
YOUR TOTAL ANNUAL PREMIUM IS	57.41

INTEREST RATE FOR BASIS OF COMPUTATION  
NONFORFEITURE RATE 5.00%

MORTALITY TABLE FOR BASIS OF COMPUTATION  
2001 COMMISSIONER'S STANDARD ORDINARY, AGE LAST BIRTHDAY,  
MALE, SMOKER

## POLICY VALUES

PLAN	WHOLE LIFE INSURANCE - PREMIUMS PAYABLE FOR LIFE				
POLICY NUMBER	8-001001				
INSURED	JOHN DOE				
ISSUE DATE	01-31-2011	AGE AT ISSUE	35	SEX	MALE

### TABLE OF VALUES PER INITIAL FACE AMOUNT OF \$1,000

END OF YEAR	END OF YEAR DEATH BENEFIT	END OF YEAR CASH VALUE	PERIOD OF EXTENDED TERM INSURANCE		AMOUNT OF PAID UP INSURANCE
			Years	Days	
1	1000	0.00	0	0	0
2	1000	0.00	0	0	0
3	1000	6.22	2	212	29
4	1000	16.87	5	354	77
5	1000	27.90	8	191	123
6	1000	39.29	10	284	167
7	1000	51.02	12	201	208
8	1000	63.07	13	324	248
9	1000	75.40	14	354	285
10	1000	87.99	15	319	321
11	1000	100.88	16	210	355
12	1000	114.08	17	40	387
13	1000	127.69	17	189	418
14	1000	141.82	17	310	448
15	1000	156.44	18	45	476
16	1000	171.49	18	129	504
17	1000	186.91	18	196	530
18	1000	202.62	18	243	555
19	1000	218.54	18	270	578
20	1000	234.60	18	280	600

NONFORFEITURE FACTOR	12.17397
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## POLICY DATA PAGE

POLICY NUMBER 8-001001 \$1,000 INITIAL FACE AMOUNT  
INSURED NAME JOHN DOE  
ISSUE DATE 01-31-2011  
AGE AT ISSUE 35 MALE SEX NON-NICOTINE  
POLICY OWNER JOHN DOE  
PLAN WHOLE LIFE INSURANCE - PREMIUMS PAYABLE FOR LIFE  
BENEFICIARY SEE ATTACHED APPLICATION

	ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY
DIRECT BILLING	52.54**	26.80	13.66	N/A
PRE-AUTHORIZED CHECK	52.54	26.80	13.66	4.73

THE “\*\*” FLAGS THE INITIAL MODE OF PAYMENT.

### SCHEDULE OF PREMIUMS

BIRTHDAY	ANNUAL PREMIUM
1-01-1976	52.54
YOUR TOTAL ANNUAL PREMIUM IS	52.54

INTEREST RATE FOR BASIS OF COMPUTATION  
NONFORFEITURE RATE 5.00%

MORTALITY TABLE FOR BASIS OF COMPUTATION  
2001 COMMISSIONER’S STANDARD ORDINARY, AGE LAST BIRTHDAY,  
MALE, NON-SMOKER

## POLICY VALUES

PLAN	WHOLE LIFE INSURANCE - PREMIUMS PAYABLE FOR LIFE				
POLICY NUMBER	8-001001				
INSURED	JOHN DOE				
ISSUE DATE	01-31-2011	AGE AT ISSUE	35	SEX	MALE

### TABLE OF VALUES PER INITIAL FACE AMOUNT OF \$1,000

END OF YEAR	END OF YEAR DEATH BENEFIT	END OF YEAR CASH VALUE	PERIOD OF EXTENDED TERM INSURANCE		AMOUNT OF PAID UP INSURANCE
			Years	Days	
1	1000	0.00	0	0	0
2	1000	0.00	0	0	0
3	1000	3.41	2	243	20
4	1000	11.90	7	281	69
5	1000	20.75	11	269	115
6	1000	29.95	14	266	160
7	1000	39.50	16	323	202
8	1000	49.38	18	206	243
9	1000	59.61	19	296	281
10	1000	70.17	20	274	318
11	1000	81.07	21	182	353
12	1000	92.33	22	39	386
13	1000	104.02	22	215	418
14	1000	116.19	22	349	448
15	1000	128.85	23	73	477
16	1000	141.96	23	128	505
17	1000	155.51	23	158	532
18	1000	169.46	23	162	558
19	1000	183.81	23	145	582
20	1000	198.48	23	107	605

NONFORFEITURE FACTOR	9.17498
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## DEFINITIONS

***“We,” “Us,” and “Our”*** mean American Memorial Life Insurance Company.

***“You” and “Your”*** refer to the person named as owner on the Policy Data Page. The insured is the owner, unless someone other than the insured is named. Your rights are described in the General Provisions.

***“Contingent Owner”*** is the person named by you to succeed you to the rights and privileges of this policy upon your death.

***“Insured”*** means the person named on the Policy Data Page.

***“Beneficiary”*** means the person named in the application, or in a later change of beneficiary, to receive all or part of the death benefits in the event of the insured’s death.

***“Irrevocable Beneficiary”*** is a beneficiary named by you that cannot be changed, nor can other policy changes be made, without his or her written permission.

***“Age”*** means the insured’s age as of the insured’s last birthday.

***“Issue Date”*** means the date this policy goes into effect. The policy anniversary, policy year and/or months, and premium due date are computed from this date.

***“Policy Debt”*** means debt owed to us against this policy and includes any interest accrued to date.

***“Lapse”*** is the termination of the policy due to nonpayment of premiums, subject to the Nonforfeiture Options.

***“Reinstatement”*** means to restore coverage after the policy has lapsed.

***“Cash Value”*** means the guaranteed value of the policy.

***“Per Capita Beneficiary Designation”*** means a beneficiary designation under which life insurance policy proceeds are shared only by the named group of beneficiaries to receive an equal share of life insurance proceeds for those members who survive the insured.

***“Non-Nicotine”*** means no use of cigarettes, cigars, pipe or chewing tobacco, nicotine gum, nicotine patches, or other products containing nicotine in the past twelve (12) months from the date of application.

## **DEATH BENEFITS**

The amount of the death benefit depends on the time of the insured's death and is equal to:

1. the face amount shown on the Policy Data Page; less
2. any policy debt; less
3. any due premium; plus
4. the premium paid for any period beyond the policy month in which death occurred.

We will pay interest on the death benefit at a rate not less than that required by state law.

If the insured lives to age 100, you may elect to have the benefit payable under this policy paid as a lump sum to you or held by us as a fund-on-deposit. Funds-on-deposit bear interest at a rate determined by us. Interest earned on the fund-on-deposit will be taxable to you. Unless we are otherwise notified by you, the automatic option will be to hold the benefit in a fund-on-deposit to continue to allow for availability.

## **FACILITY OF PAYMENT**

We will pay death claim proceeds to the estate of the insured if:

1. no one described in the Payment of Proceeds paragraph files a claim after the death of the insured; or
2. the beneficiary is a minor; or
3. the beneficiary is incompetent.

Instead of making payment to the estate of the insured, we may pay death claim proceeds to any relative by blood or marriage who:

1. in our judgment is equitably entitled to the proceeds; or
2. is responsible for the burial of the insured.

If the law of your state does not permit payment as described above, we will pay death claim proceeds to the estate of the insured.

## BENEFICIARY PROVISIONS

**Proof of Death** – Evidence satisfactory to the company. The death benefit will be paid when we receive due proof of the insured's death. Such proof must be submitted to us at our home office. Claim forms will be made available to the beneficiary.

**Payment of Proceeds** – Death benefits will be paid to the beneficiary in a lump sum. If a beneficiary dies before the insured, the interest of that beneficiary will end at his or her death. If there are two or more persons named as the primary beneficiary, we will make payment in equal shares to the beneficiaries. If there are no other designated beneficiaries, the death benefit will be paid to you. If you are not living, proceeds will be paid to the contingent owner, if one is named. If there is no contingent owner, the proceeds will be paid to the estate of the insured or to any of the insured's closest living relatives by blood, by legal adoption, or by marriage.

**Changing a Beneficiary** – You may change the beneficiary while the insured is living by providing us with a written request. A beneficiary change will not be effective until recorded by us at our home office. If the insured dies before we receive the change, the change will take effect on the date you signed the request. Any proceeds paid before we record a change of beneficiary will not be subject to the change.

## GENERAL PROVISIONS

**Incontestability** – This policy will be incontestable after it has been in force during the lifetime of the insured for a period of two (2) years from the issue date.

**Age or Sex** – If the insured's age or sex has been misstated, the amount payable under this policy will be the amount the premium paid would have purchased had the age or sex been correctly stated at the issue date.

**Assignment of Policy** – This policy may be assigned. No assignment will be binding on us until an executed copy is received at our home office. We assume no responsibility for the validity of any assignment. Your rights and the rights of the beneficiary may be limited by the rights of an assignee.

**The Entire Contract** – This policy and the application, a copy of which is attached, and any attached endorsements or riders, constitute the entire contract. Statements made in the application, in the absence of fraud, are considered representations and not warranties. No statement will void this policy or be used in defense of a claim unless it is contained in the written application.

**Who is Authorized to Make Changes** – Only our President, Vice President, or Secretary has the power to change any provision of this policy. Any changes must be in writing. No agent or person other than the above-named officers has the authority to change or modify this policy or waive any of its provisions.

**Suicide** – If, within two (2) years from the issue date, the insured dies as the result of suicide, while sane or insane, our liability will be limited to the return of premiums paid, less policy debt.

## **GENERAL PROVISIONS (continued)**

**Exclusions** – If the insured's death is a direct result of the commission of a felony, our liability will be limited to the return of premiums paid, less policy debt.

**Policy Debt** – Policy debt will be deducted from any settlement under this policy.

**Policy Owner** – Before the insured's death, only you will be entitled to the rights granted by this policy. These rights are limited if the policy has been assigned or if an irrevocable beneficiary has been named. If you die before the insured, your rights belong to the contingent owner, if one is named; otherwise, your rights belong to the insured.

**Change in Plan** – This policy may be changed to another plan of insurance with our consent. A change of plan will be subject to the requirements and payment of charges as we determine.

**Nonparticipating** – This policy does not participate in our profits or surplus.

**Mediation** – In the event of any dispute with respect to the policy, parties are invited to consider mediation. Said mediation is not mandatory. It is optional and nonbinding unless both parties agree to it. This provision shall be inapplicable in those states that prohibit the use of mediation provisions.

## **TERMINATION**

**Termination of a Policy** – A policy will terminate upon the death of the insured, maturity or endowment of the policy, or surrender of the policy.

## PREMIUMS AND REINSTATEMENT

**Premiums** – To keep this policy in force, premiums must be paid during the lifetime of the insured on or before the date they are due. All premiums must be paid at our home office or to an agent authorized by us. Upon request, we will issue a receipt for any premiums paid. The first premium is due as of the issue date. Subsequent premiums are payable while the insured is living and within the grace period. If any premium remains unpaid after the grace period, this policy will lapse, subject to the Automatic Premium Loan and Nonforfeiture Options.

**Grace Period** – A thirty-one (31) day grace period will be allowed for the payment of each premium after the first, during which time this policy will remain inforce. The grace period does not change any due date. If the premium has not been paid, and the insured dies within the grace period, the amount of the premium due will be deducted from the proceeds payable.

**Reinstatement** – A written request for reinstatement must be made within five (5) years from the date of premium in default. The following conditions must also be met:

1. We must be provided with evidence of insurability satisfactory to us;
2. All past-due premiums must be paid, with interest compounded annually, at the rate of six percent (6%) per year;
3. The premium due at the time of reinstatement must be paid;
4. Any policy debt that existed at the time of lapse must be paid or reinstated, with interest compounded annually at the rate of six percent (6%) per year; and
5. The policy has not been surrendered for its cash value. The policy will be incontestable after it has been reinstated during the lifetime of the insured for a period of two (2) years from the reinstatement date.

## LOAN PROVISIONS

**Loans** – You can borrow against the policy, by making a written request, subject to the following conditions:

1. The maximum amount that can be borrowed is the cash value at the end of the policy year in which the loan is made, less
  - a. any existing policy debt;
  - b. interest on the loan to the end of the policy year; and
  - c. premiums payable to the end of the policy year.
2. The interest rate payable on policy debt will be eight percent (8.0%) per year payable in arrears. If interest is not paid when due, it will be added to policy debt and will bear interest at the same rate.
3. The written consent of all assignees and of any irrevocable beneficiary must be obtained in writing before a loan can be made.
4. Extended Term Insurance has no loan value.
5. The policy is assigned to us while there is a loan.

**Repayment** – Unless policy debt has been repaid under a Nonforfeiture Option, any part of the policy debt may be repaid during the life of the insured. Failure to repay policy debt will terminate this policy only if the policy debt exceeds the cash value and thirty-one (31) days have passed after we mailed notice of termination to your last known address and the address of any assignee of record.

**Automatic Premium Loan** – If this option is selected, any premium that remains unpaid at the end of the grace period will be paid by charging the premium as a loan against the policy. You will be notified if a premium loan is made. You may terminate this provision by notifying us in writing. All automatic premium loans will be subject to the same terms as any other loan made on this policy.

The premium charged as a loan will be the premium necessary to keep the policy in force to the next policy anniversary. If the cash value is not enough to allow that amount to be charged, no less than a monthly premium will be charged. If the cash value is not enough for a monthly premium to be charged, the Nonforfeiture Options will apply.

## NONFORFEITURE OPTIONS

The values shown in the Policy Values page may be used to provide extended term insurance, paid up insurance, or taken in cash upon surrender of this policy. You may elect, within three (3) months after the due date of the premium in default, any of the following options:

**Option I, Cash Surrender** – You may surrender this policy to us at our home office for the cash value. Cash values for all years will be equal to the present value of future benefits, less the present value of future nonforfeiture factors, and less policy debt. The cash value within ninety (90) days after the due date of any premium in default will be the same as the cash value on the premium due date. If the policy has been assigned, or if an irrevocable beneficiary has been named, you may not surrender the policy without the assignee's or the irrevocable beneficiary's consent.

**Option II, Extended Term Insurance** – You may continue this policy as extended term insurance in an amount equal to the death benefit decreased by the amount of any policy debt, for a term starting with the due date of the unpaid premium and for such a period as the net cash value will purchase at the insured's then attained age.

Any insurance continued in force under Option II may be surrendered for a cash surrender value not less than the present value of future guaranteed benefits on such anniversary.

**Option III, Paid Up Insurance** – This policy may be continued as paid up insurance beginning on the due date of the unpaid premium. Paid up insurance will stay in force for the lifetime of the insured unless it is surrendered. The initial amount of paid up insurance is the amount the net cash value will buy according to the Basis of Computation section.

**Automatic Nonforfeiture Option** – If the cash value exceeds five hundred dollars (\$500), the automatic nonforfeiture option is Option III, Paid Up Insurance. If the cash value amount available is five hundred dollars (\$500) or less, the automatic nonforfeiture option is Option II, Extended Term Insurance. The automatic nonforfeiture option will take effect as of the due date of any premium in default if an option has not been elected within thirty (30) days of any such due date.

**Deferral of Payment of Cash Value and Loans** – We may defer payment of any cash value or loan, except for loans taken for the purpose of paying premiums on any policy issued by us. Payment may be deferred for the period permitted by law, but not in excess of six (6) months after the request is received at our home office.

**Guaranteed Values** – The guaranteed values of this policy are shown in the Policy Values page. The values shown assume no indebtedness. The cash value between two consecutive dates shown will be determined by interpolation. Allowance will be made for the premiums paid for the period between such dates. The cash surrender and nonforfeiture values are in excess of, or equal to, the minimum values required by the state in which this policy is delivered. Values for years not shown will be furnished upon request.

**Basis of Computation** – The mortality and interest bases for nonforfeiture values, present values, and net single premiums are listed on the Policy Data Page. All such computations take into account that the policy is issued on the basis of the insured's age last birthday and are based on the assumption that premiums are payable annually. Nonforfeiture values are calculated under the assumption that death claims are paid at the end of the year. A detailed statement of the method of computation of the values and benefits shown in the policy has been filed with the insurance supervisory official of the state in which the policy is delivered.



**WHOLE LIFE INSURANCE  
PREMIUMS PAYABLE FOR LIFE  
ENDOWMENT AT AGE 100  
NONPARTICIPATING**

# Application for Life Insurance

American Memorial Life Insurance Company

P.O. Box 2730 • Rapid City, SD 57709

Proposed Insured: \_\_\_\_\_

HOME OFFICE USE ONLY # \_\_\_\_\_

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

## 1. Proposed Insured

First Middle Initial Last

Address: Street

City State Zip

Telephone Number: (Home) (Cell)

Date of Birth: Current Age: State of Birth:

SSN#: ☐ Male ☐ Female Height: Weight:

Drivers License Number: State:

U.S. citizen? ☐ Yes ☐ No If not, do you have an immigration card? ☐ Yes ☐ No Card #: \_\_\_\_\_

Have you applied for life insurance with any other insurance company in the last two years? ☐ Yes ☐ No

## 2. Owner Information (If different from Proposed Insured)

First Middle Initial Last

Address: Street

City State Zip

Telephone Number: (Home) (Cell)

SSN#: Relationship to Proposed Insured: \_\_\_\_\_

## 3. Primary Beneficiary

Full Name: \_\_\_\_\_

Relationship to Proposed Insured: \_\_\_\_\_

## 4. Contingent Beneficiary

Full Name: \_\_\_\_\_

Relationship to Proposed Insured: \_\_\_\_\_

## 5. Policy Information:

Face Amount: \$ Premium: \$ Effective Date: \_\_\_\_\_

Plan: ☒ Level Benefit Whole Life ☐ ☐ ☐

Has the Proposed Insured used nicotine based products in the past 12 months? ☐ Yes ☐ No

Replacement: Will the policy that you are applying for replace any existing life insurance or annuity policy? ☐ Yes ☐ No

If yes, give name and address of existing insurer & policy number, if available: \_\_\_\_\_

Policy Mailing: ☐ Agent ☐ Owner

## 6. Health Questions

**Part A Questions:** If Proposed Insured answers "YES" to any question in Part A or does not meet the height and weight requirements, he/she is not eligible for coverage. If all questions are answered "NO" in Part A, proceed to Part B and answer questions. If all questions are answered "NO" in Parts A and B and the Proposed Insured meets the height and weight requirements, he/she will be considered for the Level Benefit Whole Life Plan.

YES NO

1. ☐ ☐ Do you have any impairment, whether physical or mental, for which you need or receive assistance or supervision in performing normal activities of daily living such as bathing, toileting, eating, dressing, taking medications, or moving without any type of physical assistance, or are you currently hospitalized, confined to a bed or nursing facility, receiving hospice care, or do you require oxygen to assist in breathing?
2. Have you ever:
  - a. ☐ ☐ Had, or been medically advised to have, an internal organ transplant, or been diagnosed as having a terminal medical condition that is expected to result in death within the next 12 months?
  - b. ☐ ☐ Taken insulin by injection or other method prior to age 45 or been medically diagnosed, taken medication for, been treated or been advised to have treatment for chronic kidney disease, dialysis, kidney or liver failure, cirrhosis, liver disease, congestive heart failure (CHF), cardiomyopathy, organic brain syndrome, Alzheimer's, dementia, or Lou Gehrig's disease (ALS)?
  - c. ☐ ☐ Been diagnosed by a medical professional as having, or been medically treated or been advised to have treatment for acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the human immunodeficiency virus (HIV)?
  - d. ☐ ☐ Had more than one occurrence of any cancer or any metastasis in your lifetime (excluding Basal or Squamous cell skin cancer), or are you currently being treated or been advised to have treatment for cancer or recurrence of cancer or had an amputation caused by cancer?
  - e. ☐ ☐ Been diagnosed with neuromuscular or brain disease (including cerebral palsy, muscular dystrophy, multiple sclerosis, cystic fibrosis), systemic lupus (SLE) or paralysis of two or more extremities?
3. Within the past 24 months have you been medically diagnosed as having, been treated or been advised to have treatment for, taken medication for or been hospitalized for:
  - a. ☐ ☐ Internal cancer, leukemia, lymphoma, melanoma, Hodgkin's disease or Parkinson's disease?
  - b. ☐ ☐ Insulin shock, diabetic coma, or diabetic complications (including neuropathy, retinopathy, or amputation)?

**Part B Questions:** If the Proposed Insured answers "YES" to any question in Part B, he/she will be considered for the Modified Benefit Whole Life Plan only.

1. ☐ ☐ Within the past 24 months have you been medically diagnosed as having, been treated or been advised to have treatment for, or been hospitalized for stroke, transient ischemic attack (TIA), angina, coronary artery disease, heart attack, heart or vascular surgery (including coronary artery bypass, pacemaker, heart valve replacement, abdominal aortic aneurysm, angioplasty, stent placement) or any procedure to improve circulation to the legs, heart or brain?
2. Within the past 36 months have you:
  - a. ☐ ☐ Been medically diagnosed as having, been treated or been advised to have treatment for, or been hospitalized for schizophrenia, bipolar disorder, or alcohol or drug abuse, chronic obstructive pulmonary or lung disease (COPD), emphysema, or chronic bronchitis?
  - b. ☐ ☐ Been confined three or more times to a hospital, nursing facility, convalescent care facility or mental facility?
  - c. ☐ ☐ Been declined or postponed for life or health insurance or attempted suicide?

Current Physician and Address: \_\_\_\_\_

Are you taking any medication for any impairments listed in the above Health Questions? ☐ Yes ☐ No

**Conditions Relating to the Application:** I have read the questions and answers in all parts of this Application. I agree that they are complete and true to the best of my knowledge and belief. I agree that this Application and any supplement to the Application, if required, shall be attached to and form a part of any policy issued.

**Acknowledgement:** I have read and understand the Conditions Relating to the Application, the Medical Authorization information, and this Acknowledgement. I acknowledge receipt and review of the Notice to the Applicant and (where required by law) a Buyer's Guide and any other required preliminary cost information.

I understand and agree that no insurance agent has the authority to waive an answer to any question in the Application, pass on insurability, make or alter any contract, or waive any of the Company's rights or requirements. I understand that I (or my authorized representative) may receive a copy of this Application. I understand and agree that any policy applied for shall not take effect (except as provided in the Conditional Premium Receipt bearing the same name as this Application) unless and until

- (a) the Company has received and approved this Application for insurance;
- (b) the Company has issued a policy based upon this Application;
- (c) the policy has been issued and delivered and the first full premium has been paid and accepted by the Company during the lifetime and condition of health of the Proposed Insured as stated in this Application;
- (d) the Company has drafted the designated account for the first premium; and
- (e) the person to be insured remains alive at the time the premium payment is honored.

**SIGNATURES:**

Proposed Insured Signature \_\_\_\_\_ Date \_\_\_\_\_

Owner Signature \_\_\_\_\_ Date \_\_\_\_\_  
(If different from Proposed Insured)

Witness or Licensed Agent Signature \_\_\_\_\_ Date \_\_\_\_\_

Signed at: \_\_\_\_\_  
City State

**Agent's Statement** - I certify that the owner, proposed insured, or any person or entity is not being paid cash or promised services as an inducement to enter into this insurance transaction and that this insurance transaction will not be sold or assigned for any type of viatical settlement, senior settlement, life settlement, or any other secondary market.

Did you see the Proposed Insured at the time this application was completed? ☐ Yes ☐ No

**Replacement:** Is the insurance applied for intended to replace or change an existing life insurance or annuity policy? ☐ Yes ☐ No

If a replacement is involved, I certify that I only used company approved sales materials.

Primary Writing Agent Signature \_\_\_\_\_ State License No. \_\_\_\_\_

Secondary Writing Agent Signature \_\_\_\_\_ State License No. \_\_\_\_\_

Print Primary Writing Agent Name \_\_\_\_\_ Agent # \_\_\_\_\_ % Split \_\_\_\_\_

Print Secondary Writing Agent Name \_\_\_\_\_ Agent # \_\_\_\_\_ % Split \_\_\_\_\_

Primary Writing Agent Telephone Number \_\_\_\_\_

## 7. Payment Options

Premium Amount \$ \_\_\_\_\_

- Pre-Authorized Check Automatic Withdrawal (PAC) is the automatic withdrawal from your checking or savings account.

### ☐ Monthly:

- PAC is *only* available with a premium payment frequency of monthly.
- Future payment by check is **not** available with a premium payment frequency of monthly.
- All future payments must be PAC regardless of first payment method.

### First Payment:

☐ Check\* (Payable to AML)

☐ PAC First Pre-Authorized Withdrawal Date \_\_\_\_\_  
Month / Day

The first pre-authorized withdrawal must be within 30 calendar days of the date you sign this application. Withdrawal dates are available from the 1st - 28th of the month only. *All future pre-authorized withdrawal dates will coincide with the date requested for the first pre-authorized withdrawal.*

Future PAC Payments from ☐ Checking ☐ Savings

Name of Financial Institution \_\_\_\_\_

Routing Number \_\_\_\_\_ Account Number \_\_\_\_\_

Account Holder's Printed Name \_\_\_\_\_

Account Holder's Signature \_\_\_\_\_

If first payment method is check, the PAC withdrawal date will coincide each month on or about the effective date of the policy unless another day of the month is specified \_\_\_\_\_.  
Day

### ☐ Quarterly, ☐ Semi-Annual or ☐ Annual:

- Future payment by check is available with a premium payment frequency of quarterly, semi-annual or annual.

### First Payment:

☐ Check\* (Payable to AML)

### Future Payments:

☐ Check\* (Payable to AML)

\*When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day you make your payment, and you may not receive your check back from your financial institution. For inquiries please call **1-800-621-7162** |

Medical Authorization  
For use with Life Insurance Applications.  
This Authorization complies with the HIPAA Privacy Rule.

Proposed Insured: \_\_\_\_\_

\_\_\_\_\_  
Name of primary proposed insured/patient

\_\_\_\_\_  
Date of birth

\_\_\_\_\_  
Name of unemancipated minors

\_\_\_\_\_  
Date of birth

I authorize any health plan, physician, medical practitioner, health care professional, hospital, clinic, pharmacy benefit manager, pharmacy, MIB, Inc., laboratory, medical facility, insurance company, insurance support organization (or any of its members or affiliates), the Veteran’s Administration, my employer, consumer reporting agency, or any other health care provider that has provided payment, treatment or services to me or on my behalf or on the behalf of my unemancipated minor children (collectively, “My Providers”) to disclose the entire medical record and any other protected health information concerning me or my above named unemancipated minor children to American Memorial Life Insurance Company (“the Company”) or its reinsurers, their agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. I acknowledge receipt of the MIB, Inc. Pre-Notice and Fair Credit Reporting Act Pre-Notice.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information or that of my unemancipated minor children do not apply to this authorization and I instruct My Providers to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under the authorization at my request, as permitted by §164.508 of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act (“HIPAA Privacy Rule”).

This authorization shall remain in force for 24 months following the date of my signature below, regardless of my condition and whether living or deceased, and a copy of this authorization is as valid as the original. I understand that I have the right to obtain a copy of this authorization and to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at Attention: Privacy Task Force, P.O. Box 2730, Rapid City, SD 57709. I understand that a revocation is not effective to the extent that any of My Providers has relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the company will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policies.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record or that of my unemancipated minor children, the Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I (or my authorized representative) have received a copy of this authorization.

\_\_\_\_\_  
Signature of Primary Proposed Insured/Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Primary Proposed Insured/Personal Representative

\_\_\_\_\_  
Date

If signed by an individual’s Personal Representative, describe authority to sign on behalf of individual:  
{ } Parent                      { } Power of Attorney                      { } Legal Guardian                      { } Other \_\_\_\_\_

# THIS PAGE TO BE LEFT WITH THE APPLICANT

Proposed Insured: \_\_\_\_\_

## Notice to the Applicant

You have made a wise decision to apply for life insurance. The possibility exists that premiums paid over several years may exceed the death benefit. This notice is given to you at the time you apply for life insurance to tell you about that type of information the Company may obtain in connection with your application. We will treat all personal information about you as confidential.

**Underwriting.** Your application, together with the medical history you give, provides the initial basis for evaluation. The Company relies on the accuracy and completeness of your answers and may make inquiries, both before and after a policy is issued, to verify this information.

**Sources of Information.** The Company may request additional information from your physician(s) or hospital(s) or other medical professionals, or medical care institutions, pharmacy benefit manager, pharmacy, the Medical Information Bureau (MIB), other insurance institutions to which you have applied for insurance, your employers, agents of the Company, business associates, a governmental entity, financial institution, or consumer reporting agency. Your signature on the Acknowledgement and Medical Authorization Form permits the Company to make these inquiries. Such inquiries may be made by telephone, written correspondence, or personal interview. If the Company requests information from another insurance company, it will not request underwriting action. You have the right to know what information we have about you, to copy it, and if it is incorrect, to have it corrected. If the Company received information about you from an insurance support organization, such information may be retained by the organization and released to others. In this connection, the following notice is given to you as required by the federal and various state Fair Credit Reporting Acts. You have the right to access and correction with respect to this information. If you wish a more detailed explanation of information practices, please send your written request to **American Memorial Life Insurance Company, P.O. Box 2730, Rapid City, SD 57709**.

**Fair Credit Reporting Act Pre-Notice.** In some cases, the Company may ask an independent agency to prepare an investigative consumer report for you. This report may include information about your character, general reputation, personal characteristics such as health, finances, and mode of living, except as may be related directly or indirectly to your sexual orientation. Any information obtained by an investigative agency may be kept in its file and later given to others who have a business need for it. If an investigative consumer report is ordered by the Company, the report will include information obtained through interviews with your neighbors, friends, or others with whom you are acquainted. You may request to be interviewed in connection with the preparation of the investigative consumer report. You may request, in writing, to receive information from the Company about the nature and scope of an investigative consumer report. Within five (5) business days of receipt of such request, the Company will provide you with the name, address, and phone number of any agency the Company asks to prepare such a report. You should contact them to obtain a copy of the report.

**Medical Information Bureau, Inc. Pre-Notice.** Information regarding your insurability will be treated as confidential. American Memorial Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at **866-692-6901** (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is **50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734**.

American Memorial Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life and health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at **www.mib.com**.

## Conditional Premium Receipt

THIS RECEIPT PROVIDES COVERAGE ONLY IF CONDITIONS BELOW ARE MET.

The Company hereby acknowledges receipt of the initial premium from the Proposed Insured for which an application for insurance is made to American Memorial Life Insurance Company on the date of application and for the premium collected as stated on the application for insurance.

Life insurance and any additional benefits in the amount applied for shall be deemed to take effect as of the date of this application, subject to the terms and conditions printed below.

### Conditions of Life Insurance Coverage (Please read carefully).

Subject to the limitations of this receipt and the terms and conditions of the policy that may be issued by the Company on the basis of the application, the life insurance and any additional benefits applied for will not be deemed to take effect unless the Company, after investigation and such medical examination (if any) as it may require, is satisfied that on the date of the application the person proposed for insurance was insurable for the amount of life insurance and any additional benefits applied for according to the Company's rules and practice of selection; provided, however, that approval by the Company of the insurability of the Proposed Insured for a plan of insurance other than that applied for shall not invalidate the terms and conditions for the receipt relating to life insurance and any other additional benefit applied for.

The amount received shall be refunded if the application is declined or if a policy is issued other than as applied for and is not accepted. Any check or Pre-Authorized Check Automatic Withdrawal (PAC) is received subject to collection of funds.

American Memorial Life Insurance Company or its reinsurers may also release limited information in its file to other properly authorized life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

SERFF Tracking Number: ASLX-G127845329 State: Arkansas  
Filing Company: American Memorial Life Insurance Company State Tracking Number: 50573  
Company Tracking Number: AR01372AM00018  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Whole Life Insurance Premiums Payable for Life End  
Project Name/Number: Whole Life Insurance Premiums Payable for Life Endowment at Age 100 Nonparticipating/AR01372AM00018

## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Application		
<b>Comments:</b> Included with the filing.		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Demo - NonSmoker, Demo - Smoker		
<b>Comments:</b> Actuarial Memorandum		
<b>Attachments:</b> 1074 Age35NonNicotine.PDF 1074 Age 35Nicotine.PDF		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Guaranty Assoc. Notice		
<b>Comments:</b> Guaranty Association Notice		
<b>Attachment:</b> AR GA notice 1-04.PDF		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Compliance Certification		
<b>Comments:</b> Compliance Certification		
<b>Attachment:</b> AR Compliance Cert.PDF		



SERFF Tracking Number: ASLX-G127845329 State: Arkansas  
Filing Company: American Memorial Life Insurance Company State Tracking Number: 50573  
Company Tracking Number: AR01372AM00018  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Whole Life Insurance Premiums Payable for Life End  
Project Name/Number: Whole Life Insurance Premiums Payable for Life Endowment at Age 100 Nonparticipating/AR01372AM00018

**Item Status:**

**Status  
Date:**

**Satisfied - Item:** ADM-7100

**Comments:**

Information Notice

**Attachment:**

AR ADM-7100.PDF

**Item Status:**

**Status  
Date:**

**Satisfied - Item:** Flesch Certification

**Comments:**

Readability Certification

**Attachment:**

AR Readability.PDF

**Item Status:**

**Status  
Date:**

**Satisfied - Item:** Cover Letter

**Comments:**

Cover Letter

**Attachment:**

AR cover letter.PDF

**Limitations and Exclusions Under the  
Arkansas Life and Health Insurance  
Guaranty Association Act**

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association (“Guaranty Association”). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers’ care in selecting companies that are well-managed and financially stable.

**Disclaimer**

The Arkansas Life and Health Insurance Guaranty Association (“Guaranty Association”) may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is *NOT* provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association  
%The Liquidation Division  
1023 West Capitol  
Little Rock, Arkansas 72201

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act (“Act”). Below is a brief summary of the Act’s coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone’s rights or obligations under the Act or the rights or obligations of the Guaranty Association.

**Coverage**

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

**Exclusions From Coverage**

However, persons owning such policies are *NOT* protected by the Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does *NOT* provide coverage for:

- any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as a non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends and voting rights and experience rating credits;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contract holders, not individuals);
- unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

#### **Limits on Amount of Coverage**

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.



## AR K A N S A S

### Certification

I hereby certify that the guidelines of the Arkansas Insurance Department regulation 19s10B have been reviewed and to the best of my knowledge, information and belief, policy forms **P-1074-S-AR and P-1146-AR** comply with these guidelines.

A handwritten signature in cursive script, reading "Jennifer Drabik".

\_\_\_\_\_  
Jennifer Drabik  
Compliance Analyst

\_\_\_\_\_  
December 27, 2011

Date



**P.O. Box 2730 - Rapid City, SD 57709-2730**

## **INFORMATION NOTICE**

Should you have any questions about your coverage, write or call as follows:

**American Memorial Life Insurance Company  
Attention: Customer Service  
P.O. Box 2730  
Rapid City, SD 57709-2730  
Telephone: (800) 533-2220**

**GEORGE T WHITE  
2551 N ARMISTEAD AVE  
HAMPTON VA 23666**

If we at American Memorial Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

**Arkansas Insurance Department  
1200 West Third Street  
Little Rock, AR 72201  
Telephone: (501) 371-2640 or (800) 852-5494**



## ARKANSAS

### Flesch Score Certification

This is to certify that the attached Life form numbers P-1074-S-AR and P-1146-AR, achieve a flesch score of 50.0 (scored with the application), and comply with the requirements of Arkansas Statutes Ann 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

A handwritten signature in cursive script, reading "Jennifer Drabik", written over a horizontal line.

Jennifer Drabik  
Compliance Analyst

December 27, 2011  
Date



December 27, 2011

Arkansas Department of Insurance  
1200 W. Third Street  
Little Rock, AR 72201-1904

Re: American Memorial Life Insurance Company  
NAIC #0019-67989      FEIN # 46-0260270  
Form P-1074-S-AR      Individual Whole Life Insurance, Premiums Payable for Life  
Form P-1146-AR      Application for Insurance

Dear Commissioner:

Enclosed for your review are individual policy forms P-1074-S-AR and application P-1146-AR. These are new forms and they do not replace any forms previously approved by you. These forms were scored together to achieve a readability score of 50. These forms were approved by our state of domicile, South Dakota, on June 20, 2011.

To the best of my knowledge and belief, these forms contain no new, unusual or possibly controversial provisions. These policies will be sold through our field force of licensed agents. No advertising materials have been developed.

Policy Form P-1074-S-AR is a nonparticipating whole life insurance plan with premiums payable for life.

Application form P-1146-AR will be used to issue these policies as well as any other policy forms to which it would apply.

We, American Memorial Life Insurance Company, will not be illustrating the referenced life policy forms. Should our decision not to illustrate change, we will notify the Department of our intent to illustrate.

Enclosed for your review is our cover letter, policy and application forms, actuarial demonstrations as well as any applicable certifications. Your review is appreciated. If you have any questions or comments regarding this filing, please feel free to contact me either by phone (605-719-0073), by fax (605-719-0473) or by e-mail (jennifer.drabik@assurant.com). Thank you for your time, assistance and consideration.

Sincerely,

AMERICAN MEMORIAL LIFE INSURANCE COMPANY

A handwritten signature in black ink that reads "Jennifer Drabik". The signature is written in a cursive, flowing style.

Jennifer Drabik  
Compliance Analyst

:jld

American Memorial Life Insurance Company  
Statement of Variations

**Policy P-1074-S-AR**

These items can be included as shown or changed as follows:

- [1] The address and/or telephone number could change in the future.
- [2] The signatures of Secretary and President could change in the future.

In addition to the items listed above, this form is subject to only minor modification in paper size and stock, ink, shading, border, company logo and adaptation to computer printing.

**Application P-1146-AR**

These items can be included as shown or changed as follows:

- [1] The address and/or telephone number could change in the future.
- [2] Plan - In the future, there could be possible changes to this section of removing or adding a product and/or particular payment plan (3 pay, 5 pay, etc.). This could happen due to changes in our marketing plan. However, please note that we will not add any products or payment plans that have not been approved by you.
- [3] The HIPAA privacy rules could change in the future.
- [4] Outside company/organizations address and/or telephone number could change in the future.

In addition to the items listed above, this form is subject to only minor modification in paper size and stock, ink, shading, border, company logo and adaptation to computer printing.



SERFF Tracking Number: ASLX-G127845329 State: Arkansas

Filing Company: American Memorial Life Insurance Company State Tracking Number: 50573

Company Tracking Number: AR01372AM00018

TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: Whole Life Insurance Premiums Payable for Life End

Project Name/Number: Whole Life Insurance Premiums Payable for Life Endowment at Age 100 Nonparticipating/AR01372AM00018

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
12/27/2011	Supporting Document	Demo - NonSmoker, Demo - Smoker	01/03/2012	Age 35 NonSmoker.PDF (Superseded) Age 35 Smoker.PDF (Superseded)
12/27/2011	Form	Application for Insurance	12/29/2011	P-1146-AR 6-11.PDF (Superseded)

# Application for Life Insurance

American Memorial Life Insurance Company

P.O. Box 2730 • Rapid City, SD 57709

Proposed Insured: \_\_\_\_\_

HOME OFFICE USE ONLY # \_\_\_\_\_

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

## 1. Proposed Insured

First Middle Initial Last

Address: Street

City State Zip

Telephone Number: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Current Age: \_\_\_\_\_ State of Birth: \_\_\_\_\_

SSN#: \_\_\_\_\_ ☐ Male ☐ Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Drivers License Number: \_\_\_\_\_ State: \_\_\_\_\_

U.S. citizen? ☐ Yes ☐ No If not, do you have an immigration card? ☐ Yes ☐ No Card #: \_\_\_\_\_

Have you applied for life insurance with any other insurance company in the last two years? ☐ Yes ☐ No

## 2. Owner Information (If different from Proposed Insured)

First Middle Initial Last

Address: Street

City State Zip

Telephone Number: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

SSN#: \_\_\_\_\_ Relationship to Proposed Insured: \_\_\_\_\_

## 3. Primary Beneficiary

Full Name: \_\_\_\_\_

Relationship to Proposed Insured: \_\_\_\_\_

## 4. Contingent Beneficiary

Full Name: \_\_\_\_\_

Relationship to Proposed Insured: \_\_\_\_\_

## 5. Policy Information:

Face Amount: \$ \_\_\_\_\_ Premium: \$ \_\_\_\_\_ Effective Date: \_\_\_\_\_

Plan: ☒ Level Benefit Whole Life

Has the Proposed Insured used nicotine based products in the past 12 months? ☐ Yes ☐ No

Replacement: Will the policy that you are applying for replace any existing life insurance or annuity policy? ☐ Yes ☐ No

If yes, give name and address of existing insurer & policy number, if available: \_\_\_\_\_

Policy Mailing: ☐ Agent ☐ Owner

## 6. Health Questions

**Part A Questions:** If Proposed Insured answers "YES" to any question in Part A or does not meet the height and weight requirements, he/she is not eligible for coverage. If all questions are answered "NO" in Part A, proceed to Part B and answer questions. If all questions are answered "NO" in Parts A and B and the Proposed Insured meets the height and weight requirements, he/she will be considered for the Level Benefit Whole Life Plan.

YES NO

1. ☐ Do you have any impairment, whether physical or mental, for which you need or receive assistance or supervision in performing normal activities of daily living such as bathing, toileting, eating, dressing, taking medications, or moving without any type of physical assistance, or are you currently hospitalized, confined to a bed or nursing facility, receiving hospice care, or do you require oxygen to assist in breathing?
  
2. Have you ever:
  - a. ☐ Had, or been medically advised to have, an internal organ transplant, or been diagnosed as having a terminal medical condition that is expected to result in death within the next 12 months?
  - b. ☐ Taken insulin by injection or other method prior to age 45 or been medically diagnosed, taken medication for, been treated or been advised to have treatment for chronic kidney disease, dialysis, kidney or liver failure, cirrhosis, liver disease, congestive heart failure (CHF), cardiomyopathy, organic brain syndrome, Alzheimer's, dementia, or Lou Gehrig's disease (ALS)?
  - c. ☐ Been diagnosed by a medical professional as having, or been medically treated or been advised to have treatment for acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the human immunodeficiency virus (HIV)?
  - d. ☐ Had more than one occurrence of any cancer or any metastasis in your lifetime (excluding Basal or Squamous cell skin cancer), or are you currently being treated or been advised to have treatment for cancer or recurrence of cancer or had an amputation caused by cancer?
  - e. ☐ Been diagnosed with neuromuscular or brain disease (including cerebral palsy, muscular dystrophy, multiple sclerosis, cystic fibrosis), systemic lupus (SLE) or paralysis of two or more extremities?
  
3. Within the past 24 months have you been medically diagnosed as having, been treated or been advised to have treatment for, taken medication for or been hospitalized for:
  - a. ☐ Internal cancer, leukemia, lymphoma, melanoma, Hodgkin's disease or Parkinson's disease?
  - b. ☐ Insulin shock, diabetic coma, or diabetic complications (including neuropathy, retinopathy, or amputation)?

Current Physician and Address: \_\_\_\_\_

Are you taking any medication for any impairments listed in the above Health Questions? ☐ Yes ☐ No

**Conditions Relating to the Application:** I have read the questions and answers in all parts of this Application. I agree that they are complete and true to the best of my knowledge and belief. I agree that this Application and any supplement to the Application, if required, shall be attached to and form a part of any policy issued.

**Acknowledgement:** I have read and understand the Conditions Relating to the Application, the Medical Authorization information, and this Acknowledgement. I acknowledge receipt and review of the Notice to the Applicant and (where required by law) a Buyer's Guide and any other required preliminary cost information.

I understand and agree that no insurance agent has the authority to waive an answer to any question in the Application, pass on insurability, make or alter any contract, or waive any of the Company's rights or requirements. I understand that I (or my authorized representative) may receive a copy of this Application. I understand and agree that any policy applied for shall not take effect (except as provided in the Conditional Premium Receipt bearing the same name as this Application) unless and until

- (a) the Company has received and approved this Application for insurance;
- (b) the Company has issued a policy based upon this Application;
- (c) the policy has been issued and delivered and the first full premium has been paid and accepted by the Company during the lifetime and condition of health of the Proposed Insured as stated in this Application;
- (d) the Company has drafted the designated account for the first premium; and
- (e) the person to be insured remains alive at the time the premium payment is honored.

**SIGNATURES:**

Proposed Insured Signature \_\_\_\_\_ Date \_\_\_\_\_

Owner Signature \_\_\_\_\_ Date \_\_\_\_\_  
(If different from Proposed Insured)

Witness or Licensed Agent Signature \_\_\_\_\_ Date \_\_\_\_\_

Signed at: \_\_\_\_\_  
City State

**Agent's Statement** - I certify that the owner, proposed insured, or any person or entity is not being paid cash or promised services as an inducement to enter into this insurance transaction and that this insurance transaction will not be sold or assigned for any type of viatical settlement, senior settlement, life settlement, or any other secondary market.

Did you see the Proposed Insured at the time this application was completed? ☐ Yes ☐ No

**Replacement:** Is the insurance applied for intended to replace or change an existing life insurance or annuity policy? ☐ Yes ☐ No

If a replacement is involved, I certify that I only used company approved sales materials.

Primary Writing Agent Signature \_\_\_\_\_ State License No. \_\_\_\_\_

Secondary Writing Agent Signature \_\_\_\_\_ State License No. \_\_\_\_\_

Print Primary Writing Agent Name \_\_\_\_\_ Agent # \_\_\_\_\_ % Split \_\_\_\_\_

Print Secondary Writing Agent Name \_\_\_\_\_ Agent # \_\_\_\_\_ % Split \_\_\_\_\_

Primary Writing Agent Telephone Number \_\_\_\_\_

## 7. Payment Options

Premium Amount \$ \_\_\_\_\_

- Pre-Authorized Check Automatic Withdrawal (PAC) is the automatic withdrawal from your checking or savings account.

### ☐ Monthly:

- PAC is *only* available with a premium payment frequency of monthly.
- Future payment by check is **not** available with a premium payment frequency of monthly.
- All future payments must be PAC regardless of first payment method.

### First Payment:

☐ Check\* (Payable to AML)

☐ PAC First Pre-Authorized Withdrawal Date \_\_\_\_\_  
Month / Day

The first pre-authorized withdrawal must be within 30 calendar days of the date you sign this application. Withdrawal dates are available from the 1st - 28th of the month only. *All future pre-authorized withdrawal dates will coincide with the date requested for the first pre-authorized withdrawal.*

Future PAC Payments from ☐ Checking ☐ Savings

Name of Financial Institution \_\_\_\_\_

Routing Number \_\_\_\_\_ Account Number \_\_\_\_\_

Account Holder's Printed Name \_\_\_\_\_

Account Holder's Signature \_\_\_\_\_

If first payment method is check, the PAC withdrawal date will coincide each month on or about the effective date of the policy unless another day of the month is specified \_\_\_\_\_.  
Day

### ☐ Quarterly, ☐ Semi-Annual or ☐ Annual:

- Future payment by check is available with a premium payment frequency of quarterly, semi-annual or annual.

### First Payment:

☐ Check\* (Payable to AML)

### Future Payments:

☐ Check\* (Payable to AML)

\*When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day you make your payment, and you may not receive your check back from your financial institution. For inquiries please call **1-800-621-7162** |

This Authorization complies with the HIPAA Privacy Rule.

6/11

# THIS PAGE TO BE LEFT WITH THE APPLICANT

Proposed Insured: \_\_\_\_\_

## Notice to the Applicant

You have made a wise decision to apply for life insurance. The possibility exists that premiums paid over several years may exceed the death benefit. This notice is given to you at the time you apply for life insurance to tell you about that type of information the Company may obtain in connection with your application. We will treat all personal information about you as confidential.

**Underwriting.** Your application, together with the medical history you give, provides the initial basis for evaluation. The Company relies on the accuracy and completeness of your answers and may make inquiries, both before and after a policy is issued, to verify this information.

**Sources of Information.** The Company may request additional information from your physician(s) or hospital(s) or other medical professionals, or medical care institutions, pharmacy benefit manager, pharmacy, the Medical Information Bureau (MIB), other insurance institutions to which you have applied for insurance, your employers, agents of the Company, business associates, a governmental entity, financial institution, or consumer reporting agency. Your signature on the Acknowledgement and Medical Authorization Form permits the Company to make these inquiries. Such inquiries may be made by telephone, written correspondence, or personal interview. If the Company requests information from another insurance company, it will not request underwriting action. You have the right to know what information we have about you, to copy it, and if it is incorrect, to have it corrected. If the Company received information about you from an insurance support organization, such information may be retained by the organization and released to others. In this connection, the following notice is given to you as required by the federal and various state Fair Credit Reporting Acts. You have the right to access and correction with respect to this information. If you wish a more detailed explanation of information practices, please send your written request to **American Memorial Life Insurance Company, P.O. Box 2730, Rapid City, SD 57709**.

**Fair Credit Reporting Act Pre-Notice.** In some cases, the Company may ask an independent agency to prepare an investigative consumer report for you. This report may include information about your character, general reputation, personal characteristics such as health, finances, and mode of living, except as may be related directly or indirectly to your sexual orientation. Any information obtained by an investigative agency may be kept in its file and later given to others who have a business need for it. If an investigative consumer report is ordered by the Company, the report will include information obtained through interviews with your neighbors, friends, or others with whom you are acquainted. You may request to be interviewed in connection with the preparation of the investigative consumer report. You may request, in writing, to receive information from the Company about the nature and scope of an investigative consumer report. Within five (5) business days of receipt of such request, the Company will provide you with the name, address, and phone number of any agency the Company asks to prepare such a report. You should contact them to obtain a copy of the report.

**Medical Information Bureau, Inc. Pre-Notice.** Information regarding your insurability will be treated as confidential. American Memorial Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at **866-692-6901** (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is **50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734**.

American Memorial Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life and health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at **www.mib.com**.

## Conditional Premium Receipt

THIS RECEIPT PROVIDES COVERAGE ONLY IF CONDITIONS BELOW ARE MET.

The Company hereby acknowledges receipt of the initial premium from the Proposed Insured for which an application for insurance is made to American Memorial Life Insurance Company on the date of application and for the premium collected as stated on the application for insurance.

Life insurance and any additional benefits in the amount applied for shall be deemed to take effect as of the date of this application, subject to the terms and conditions printed below.

### Conditions of Life Insurance Coverage (Please read carefully).

Subject to the limitations of this receipt and the terms and conditions of the policy that may be issued by the Company on the basis of the application, the life insurance and any additional benefits applied for will not be deemed to take effect unless the Company, after investigation and such medical examination (if any) as it may require, is satisfied that on the date of the application the person proposed for insurance was insurable for the amount of life insurance and any additional benefits applied for according to the Company's rules and practice of selection; provided, however, that approval by the Company of the insurability of the Proposed Insured for a plan of insurance other than that applied for shall not invalidate the terms and conditions for the receipt relating to life insurance and any other additional benefit applied for.

The amount received shall be refunded if the application is declined or if a policy is issued other than as applied for and is not accepted. Any check or Pre-Authorized Check Automatic Withdrawal (PAC) is received subject to collection of funds.

American Memorial Life Insurance Company or its reinsurers may also release limited information in its file to other properly authorized life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.